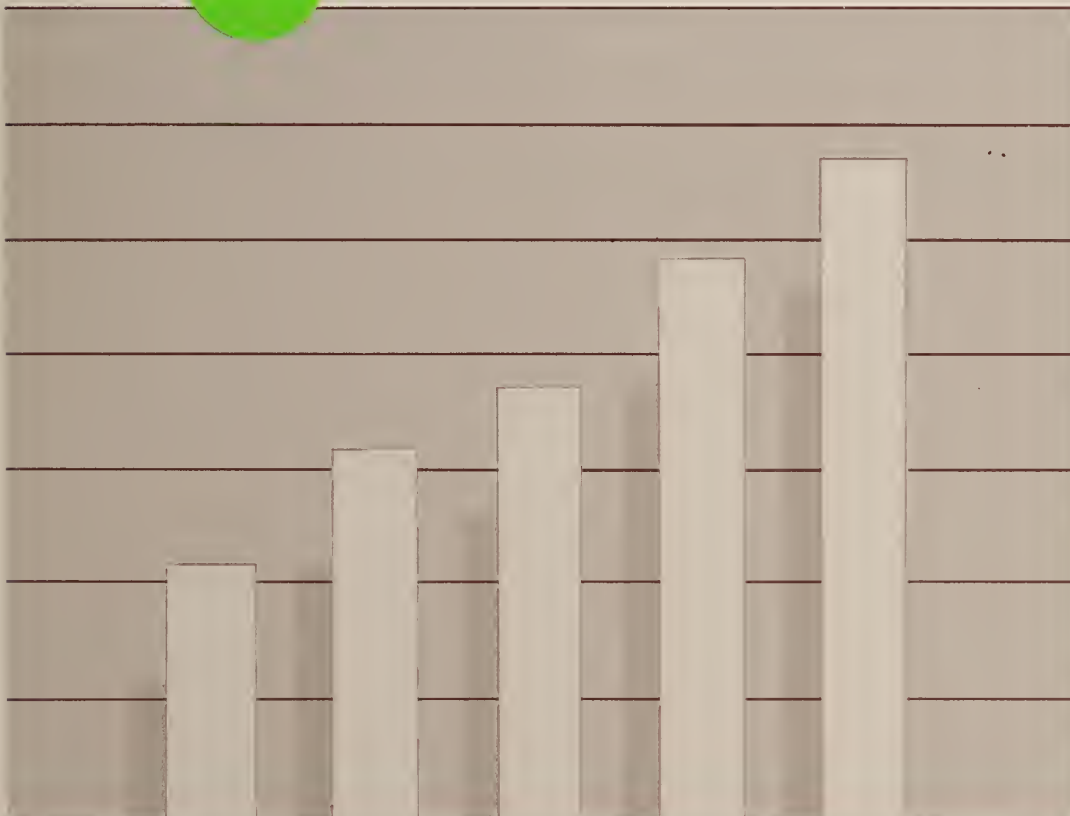

PHYSICIAN

PAYMENT REVIEW

COMMISSION

 Executive Summary



Annual Report to Congress

1990

PREFACE

In 1986 the Congress created the Physician Payment Review Commission to advise it on reforms of the methods used to pay physicians under the Medicare program. Since that time, the Commission has conducted analyses of physician payment issues, provided a forum for groups representing beneficiaries, physicians and other interests to present their views, and worked closely with the Congress to reshape Medicare policy. The Commission has been guided by the principles that payment reform should maintain financial protection for beneficiaries, provide equitable payment for physicians and slow the rate of increase in Medicare expenditures.

In its 1989 report to Congress, the Commission presented a comprehensive set of proposals for Medicare physician payment reform. The Congress drew heavily on the Commission's recommendations in developing legislation that was enacted in November 1989. The 1990 report is devoted to examining a number of remaining policy and technical issues that must be resolved before the legislation is implemented in 1992. It also provides a progress report on several studies that the Congress has requested the Commission to undertake and sets out work plans for new issues the Commission plans to take up in the coming year.

Over the past few years, the Commissioners and staff have come to appreciate the major contributions made to the Commission's work by other government agencies, private organizations and many individuals. During the past year, staff of the Health Care Financing Administration and other agencies of the Department of Health and Human Services, the Congress, the Office of Technology Assessment, the Congressional Budget Office, the Congressional Research Service, the General Accounting Office, and the Prospective Payment Assessment Commission provided many kinds of information and assistance to the Commission.

Social and Scientific Systems, especially Jansen Davis, Paul Menick and Arlene Turner, provided exceptional programming support for many aspects of the Commission's work. Lynn Lewis provided very timely and helpful editing of the report that was much appreciated by the staff.

The Commission has continued to draw on the advice of physicians, beneficiaries, Medicare carriers, and other experts on physician payment issues. It has benefitted from their public testimony, information they have provided, their participation in Commission consensus process activities, and their comments on the draft chapters of this report. The

Commission is particularly appreciative of the efforts made by surgical specialty societies to provide data on pre and postoperative visits to be used in assigning relative values to surgical global services.

Among the many people who contributed to the Commission's work in the past year, we would like to single out the following who were particularly helpful to the staff and Commissioners: Kathy Banks, Marc Berk, Jack Bierig, Sandra Christensen, Benson Dutton, Jose Escarce, James Fossett, George Greenberg, Linda Hall, Scott Harrison, David Helms, Edward Hirschfeld, Pam Johnson, Terrance Kay, Jesse Levy, Lisa Looper, John Luehrs, Carole Magoffin, Susan Marquis, Ron Menaker, Jim Mikula, Cindy Moser, Dale Mulholland, Gregory Nycz, Peter Oswald, Julia Paradise, Bernard Patashnik, Janet Perloff, Ronald Pfannerstill, Steve Raetzman, Dwight Ruff, Bonnie Thielke, Andy Webber, W. Pete Welch, Frederick Wenzel, Brian Winkel, Donald Zais, Steve Zuckerman. Special thanks also go to Janet Corrigan, Herschel Goldfield, Ann Mongoven, and Julie Swartzman whose work with the Commission staff is reflected in a number of chapters of this report.

March 1990

Philip R. Lee, M.D.
Chairman

PHYSICIAN PAYMENT REVIEW COMMISSION

COMMISSION MEMBERS

Philip R. Lee, M.D., Chairman
Director
Institute for Health Policy Studies
University of California, San Francisco, CA

Jim Bob Brame, M.D.
Private Practice of Medicine
Eldorado, TX

P. William Curreri, M.D.
President
Strategem of Alabama, Inc.
Mobile, AL

Karen Davis, Ph.D.
Chairman
Department of Health Policy
and Management
The Johns Hopkins University
Baltimore, MD

John M. Eisenberg, M.D., M.B.A.
Sol Katz Professor of General
Internal Medicine
Hospital of the University
of Pennsylvania
Philadelphia, PA

Jack Guildroy
Board of Directors
American Association of
Retired Persons
Port Washington, NY

Mark C. Hornbrook, Ph.D.
Senior Investigator and
Senior Economist
Center for Health Research
Kaiser Permanente, NW Region
Portland, OR

Robert B. Keller, M.D. ¹
Private Practice of Medicine and
Executive Director
Maine Medical Assessment
Foundation
Belfast, ME 04915

Carol Ann Lockhart, Ph.D., R.N.,
F.A.A.N.
Director
Greater Phoenix Affordable
Health Care Foundation
Phoenix, AZ

Walter B. Maher
Director, Federal Relations
Human Resources Office
Chrysler Motors Corporation
Washington, DC

Walter J. McNerney
Professor of Health Policy
J.L. Kellogg Graduate School
of Management
Northwestern University
Evanston, IL

Thomas R. Reardon, M.D.
Private Practice of Medicine
Portland, OR

Uwe R. Reinhardt, Ph.D.
James Madison Professor of
Political Economy
Woodrow Wilson School
Princeton University
Princeton, NJ

Gail R. Wilensky, Ph.D.
Vice President
Project Hope
Chevy Chase, MD

¹ Gail R. Wilensky, Ph.D., resigned from the Commission effective January 18, 1990, to become Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services. Robert B. Keller, M.D., was appointed to fulfill the remainder of Dr. Wilensky's term.

COMMISSION STAFF

Paul B. Ginsburg, Ph.D., Executive Director
Glenn T. Hammons, M.D., Deputy Director
Lauren B. LeRoy, Ph.D., Deputy Director

Principal Policy Analysts

David C. Colby, Ph.D.
Roz Diane Lasker, M.D.

Senior Analysts

Jill Bernstein, Ph.D.
Christopher Hogan, Ph.D.
David Juba
William Koprowski, Ph.D.¹
Curt Mueller, Ph.D.
Carlos Muñoz, Ph.D.¹
Thomas Rice, Ph.D.²

Analysts

James Bahr
Maureen Molloy
Anne Schwartz
Anthony Tucker

Junior Analysts

Katherine Macenko
Susan Wall

Administrative Staff

Joyce Añonuevo
Ann Johnson
Norma Leake
Sheran McManus
Faye Outten-Kirk

¹ Drs. Koprowski and Muñoz are working with the Commission through the Robert Wood Johnson Faculty Fellowship Program in Health Finance.

² Dr. Rice is on sabbatical leave from the University of North Carolina.

EXECUTIVE SUMMARY

With this fourth annual report to Congress, the Physician Payment Review Commission begins a new phase in its responsibilities to advise the Congress on physician payment in the Medicare program. Its first three annual reports were devoted to developing a multifaceted reform of physician payment. The 1989 report reflected the culmination of this work, presenting a comprehensive proposal that included four major elements: a Medicare fee schedule, balance billing limits, expenditure targets, and a program of effectiveness research and development of practice guidelines (PPRC, 1989a). In addition, the Commission has provided budget advice to the Congress each year, identifying how it could meet annual budget objectives while moving the payment system toward long-term reform.

THE 1989 LEGISLATION

In its first report to Congress in March 1987, the Commission described its goals for reform of Medicare payment to physicians. They included improving financial protection for beneficiaries, improving equity among physicians, containing the costs of physicians' services to the Medicare program and its beneficiaries, and simplifying administration. The Omnibus Budget Reconciliation Act of 1989 (OBRA89; P.L. 101-239) moves a long way toward meeting these goals.

Provisions of OBRA89

Beginning in 1992, Medicare payment to physicians will be based on a fee schedule. The relative value of each service will be determined by estimates of average physician time and effort, practice expense, and a separate factor for the costs of professional liability insurance (PLI). While the relative value scale (RVS) will apply nationally, the payment in each locality will depend on a geographic adjuster that reflects differences in practice expense, PLI expense, and a partial adjustment for geographic differences in the cost of living.

Limits on charges that are a uniform percentage above the fee schedule amount will replace the current physician-specific maximum allowable actual charge (MAAC) limits. These charge limits will begin in 1991 and by 1993 will be set at 115 percent of the Medicare payment amount.

The fee schedule will be fully implemented by 1996. A substantial amount of the change will occur by 1992, however, when 32 percent of services will be paid entirely on the basis of the Medicare Fee Schedule and 69 percent of the change in payment rates will have been accomplished.

The initial conversion factor, which attaches dollar amounts to the relative values, is to be calibrated to achieve budget neutrality. This means that total payments to physicians under the fee schedule are to equal the amount projected under the current system. The Commission is concerned that two technical issues related to calculating the conversion factor--the assumptions used about changes in utilization induced by the Medicare Fee Schedule and the lack of a provision for recalculating budget neutrality at each step in the transition--could be at odds with the Congress' intent.

Annual updates in the conversion factor will be based on Volume Performance Standards (VPSs). Under this policy, updates will depend largely on how increases in Medicare expenditures for physicians' services compare with a previously set standard. Each year, the Congress will set a performance standard for the rate of growth in spending for physician services. It then will compare the actual experience to this standard and determine the conversion factor update on the basis of this comparison and other factors. If Congress does not act to set either the performance standard or the update, the Health Care Financing Administration (HCFA) will apply a formula specified in OBRA89 to make that determination.

The VPS policy expresses Congress' determination to slow the growth of expenditures to an affordable rate by paying only for services that are appropriate. The policy's underlying concept is that by basing fee updates on how expenditure growth compares with a performance standard, the medical profession is given a collective incentive to foster approaches to slow expenditure growth. While these financial incentives are not intended to influence the decisions of individual practitioners directly, they do provide a reason for physicians to become more involved in efforts to contain medical costs. Physicians could, for example, work through their professional organizations to expand continuing education, develop and disseminate practice guidelines, and become more actively involved in peer review activities. Such activities could provide physicians, payers, and patients with the information they need to make better choices about appropriate medical care.

If the VPS system is to achieve the Congress' goals for cost containment through increasing appropriateness of care rather than through smaller fee updates, the medical profession must take the leading role in changing the way that physicians and patients think about using medical resources. The perceived obligation for physicians to provide and for patients to receive every service that has some marginal value regardless of cost must change.

The federal government will support the medical profession's efforts to increase appropriate use of medical resources in several ways. It will provide financial support for development of guidelines and review criteria. It will also generate and disseminate information on utilization patterns to help focus these efforts and to enhance peer review.

Much of this federal role is encompassed in the fourth component of the payment reform legislation--expanded federal support of health care research and dissemination of what is learned. OBRA89 established the Agency for Health Care Policy and Research (AHCPR) to conduct and support research on the quality, appropriateness, effectiveness, and cost of health care services. AHCPR is to use the results of this research to promote improvements in clinical practice and in the organization, financing, and delivery of health care services.

Impact of the Fee Schedule

The resource-based fee schedule will alter the pattern of physician payment in a number of important ways. Basing relative values on the time and intensity of effort required to perform different services will remove the distortions in the incentives to physicians concerning what services to provide. This will increase payment for evaluation and management (EM) services compared to that for technical procedures. Commission simulations project that if the fee schedule had been in effect in 1989, payment for primary care services (visits in offices, nursing homes, the home, and in emergency rooms) would be 30 percent higher than it was. Payment for cataract surgery and coronary artery bypass surgery would have been 23 percent and 34 percent lower.

The fee schedule will also increase revenues to specialties for which EM services comprise a substantial part of practice, such as family medicine and internal medicine. Payments to these specialties would have been 39 percent and 15 percent higher, respectively.

Both direct and indirect practice costs will be estimated from accounting data on a wide variety of practices and incorporated into the RVS. This will significantly affect payments for services in which practice costs comprise a large proportion of total resource requirements.

Geographic variation in payment for identical services will be reduced, with payment increasing for most rural practitioners. On average, payment to rural practices would have been 13 percent higher under the fee schedule.

Beneficiary liability for charges in excess of Medicare-allowed amounts will be reduced substantially. Simulations suggest that in the aggregate, liability for balance billing would

have been 75 percent lower.¹ Combined expense for coinsurance and balance billing would have been lower for 68 percent of beneficiaries and increased by \$10 per year or less for another 21 percent.

Implementation

With the outlines of payment reform clearly established, the crucial task of implementation lies ahead. Implementation involves numerous decisions about how to translate the OBRA89 provisions into an operational policy.² The Congress expects to make the most important of these decisions itself and has therefore called for various studies and recommendations. For many of the remaining policy decisions, the Congress has asked the Commission to contribute its analysis and judgment.

This report is devoted to the numerous policy issues on which the Commission has been requested to advise the Congress. The Commission's work on these issues is at different stages. For some, the Commission has made recommendations, which are presented in this report. On others, the Commission has analyzed and discussed the issues, but has not yet completed its work. The Commission expects to bring recommendations on these issues to the Congress as it completes its work during the coming year. Discussion of these issues is intended as a progress report. The Commission hopes that these discussions will help others develop their own views and help the Commission make future recommendations. For still other issues, the work is in the earliest stages. These areas are simply introduced in this report, along with a work plan.

REFINING THE SCALE OF RELATIVE WORK

The physician work component of the RVS will be based on estimates from the Resource-Based Relative Value Study prepared by William Hsiao and his colleagues at Harvard University (Hsiao et al., 1988). The Commission concluded in its 1989 report to Congress that the basic methodology was sound, but that parts of the study needed to be revised and expanded. Hsiao and his colleagues are correcting certain methodologic problems that were identified in the first phase of the study and expanding the study to cover additional

¹ This estimate is sensitive to assumptions about how physician behavior concerning assignment and balance billing will be affected by the new payment system. It assumes that physician behavior concerning assignment will not change and that for unassigned claims, submitted charges will be the same. Some alternative assumptions would suggest a smaller but substantial reduction in balance billing.

² The legislation calls on HCFA to publish a model fee schedule by September 1, 1990. While an early indication by HCFA concerning its approach to the numerous implementation decisions would be useful for all concerned, publication of actual fees for large numbers of procedures by that date would be premature and cause unnecessary confusion. Results from the second phase of the study by William Hsiao and his colleagues at Harvard University are not expected to be available in time to have been analyzed and incorporated into a model fee schedule by September 1.

services and specialties. The Commission is focusing on coding problems that need to be corrected before accurate relative work values can be assigned to EM services and surgical global services. After this work is completed, the Commission will begin to identify any remaining problems in the scale of relative work and to make necessary refinements.

Since the 1989 report, much progress has been made toward resolving coding problems. The Commission's Survey of Visits and Consultations is nearly complete. A consensus panel sponsored jointly by the Commission and the American Medical Association (AMA) has been convened and is working on incorporating time into EM definitions of levels of service. In order to calibrate the relative values for surgical global services, the Commission has been compiling and validating data provided by surgical specialty societies on pre- and postoperative visits associated with each operation.

In the fall of 1990, when the second phase of the Hsiao study and the Commission's work on coding are complete, the Commission will begin a formal process to review and refine the scale of relative work. Specialty societies will be asked to identify problems related to the relative work values (RWVs) for surveyed services, the cross-specialty links, and the families of services and benchmark services used in the extrapolations. These problems will be corrected by the Commission, in consultation with representatives of the Hsiao team, the AMA, HCFA, and an interspecialty panel of physicians. The Commission will also convene specialty-specific advisory panels of physicians to help it refine RWVs developed through extrapolation. Most of the refinements will be completed by the summer of 1991.

The scale of relative work may need further refinements to make it applicable to the care of Medicare patients. In the Hsiao study, each estimate reflects the relative amount of work involved in providing a service to the typical patient in the general population who receives it. But the Medicare Fee Schedule will apply to a more selective population: patients who are 65 years of age or older or disabled. The Commission plans to identify RWV estimates that do not reflect the work involved in caring for typical Medicare patients and to obtain data to determine whether these differences are significant. If substantial differences are identified, the Commission will calculate "Medicare adjusters" to the RWVs for those services. This will permit the Medicare program to tailor the RVS to the needs of its beneficiaries, while leaving intact an RVS applicable to a general population for use by other payers. Severity of illness modifiers may also be needed to differentiate relative values for some services delivered to atypical Medicare patients.

PRACTICE EXPENSE

Practice expense constitutes almost half of the resources that are to be allocated to the services in the RVS. Much of practice expense constitutes overhead, in that a given

resource is used to produce all or most physician services. Office rent is an example. But some practice expense supports only a limited range of services--for example, capital costs of X-ray equipment.

OBRA89 specifies a relatively crude method for assigning practice expense to individual services, but the Congress is looking to the Commission to develop more accurate estimates. The Commission is guided by two principles in developing rules to assign practice expense to services. First, it should be assigned so that physicians have neutral incentives to provide one service rather than another. This implies that costs specific to a procedure are identified with it and that general overhead components of practice expense are allocated in proportion to the physician's direct involvement.³

Second, practice expense should be assigned to services so that the average physician providing the service recovers his or her practice expense.⁴ When the second principle is applied to different practice types, trade-offs between the two principles may be required. Methods for allocating practice costs to services will not affect the aggregate amount of Medicare payment for physicians' services, however, since OBRA89 specifies a budget neutral conversion factor.

The Commission is developing data on practice expense that is specific to services or categories of related services. It has been working with large fee-for-service multispecialty group practices with sophisticated accounting systems that can identify the direct costs of equipment, specialized personnel, and supplies required to provide particular services in physicians' offices or clinics. These data will supplement data from surveys of physicians by providing detail on practice expense for services using specialized resources. Other data, such as the Commission's 1988 Survey of Physicians, the most recent Medical Group Management Association Survey of Group Practices, and planned case studies of smaller practices will be used to adjust the data from the large multispecialty group practices to be representative of medical practice.

³ The physician's direct involvement could be measured either as total time or total work.

⁴ Allocating practice expense on the basis of the average practice will, for some services, lead to a payment that will not be high enough to cover costs in all possible settings. The Commission confronted this issue in its report to Congress on the costs of screening mammography (PPRC, 1989b). (Coverage for the service has since been repealed.) It concluded that the Medicare payment for screening would have been adequate to cover costs in specialized mammography centers, radiology practices, or multispecialty group practices, but not the costs of providing the service in the solo practice of a family physician. The Commission decided not to recommend that payments be set high enough to cover the costs in primary care settings. The Commission did recommend higher payments for screening mammography in remote rural areas since efficient use of specialized resources is often not feasible and diffusion of the technology to such areas (through mobile centers) is warranted.

PROFESSIONAL LIABILITY EXPENSE

OBRA89 specifies a separate RVS component for costs of professional liability insurance. The Commission suggested the distinction in order to highlight the magnitude of malpractice insurance costs and to permit application of a method of allocating these costs that differs from that for other practice costs.

Malpractice premiums are determined mostly on the basis of a physician's specialty and practice location. Consequently, a separate component for PLI expense permits assigning these costs according to a physician's specialty as part of a policy that does not otherwise recognize specialty differentials. The mechanism for incorporating PLI expense specified in OBRA89 does not accomplish this, however.

According to the legislation, the malpractice expense component for a service reflects a weighted average of ratios of malpractice premiums to revenues for those specialties that provide the service. But this will cause the average physician in some high-risk specialties to be unable to cover PLI costs since some services (for example, EM services) overlap with those of low-risk specialties.

The legislation anticipates refinement in the method by which PLI costs are paid. Studies have been requested of both the General Accounting Office and the Commission on various options. Among these are assigning PLI costs by risk class of the physician, by type of service, by reimbursing a portion of each physician's premium, and by covering liability claims from Medicare patients through the federal government.

The Commission has not yet developed a recommendation on payment for PLI costs. A chapter in this report outlines the data and administrative requirements of each option and describes the trade-offs among accuracy, efficiency, and administrability. The risk-class option appears to satisfy both of the principles of practice expense assignment. The Commission is attempting to modify the type-of-service option so that the average physician in a high-risk specialty is able to recover PLI costs through the fee schedule. The direct reimbursement tailors the payment to the physician's premium costs, but raises potential administrative problems that require further study. Although the Commission has not yet examined federal provision of coverage, some see this option as a potential vehicle to test tort reform.

DEFINING PAYMENT AREAS FOR THE MEDICARE FEE SCHEDULE

OBRA89 applies geographic adjusters to existing payment localities but directs the Commission to report by July 1991 on alternative payment area configurations. The

current payment areas have been chosen by each carrier and reflect a variety of configurations with no consistent philosophy.

The Commission has identified several principles for evaluating alternative payment area configurations. Payment areas should allow for accurately tracking geographic variation in practice input prices, minimize differences in the geographic adjusters across area boundaries, and be simple to administer and understand.

The report presents a preliminary assessment of three major payment area configurations: current carrier charge localities, payment areas for each metropolitan statistical area (MSA) within a state and for the nonmetropolitan counties of each state, and statewide areas.

To put this issue in perspective, it is important to realize that the impact of the geographic adjuster specified in OBRA89 is much larger than the effect of alternative payment area configurations in determining geographic variation in payment rates. Under any of the payment area configurations being considered, geographic variation in payment would be reduced compared with that under the current customary, prevailing, and reasonable (CPR) charge methodology. Using the geographic adjuster will reduce variation across individual localities, as well as overall differences between urban and rural areas.

Data analysis suggests that for alternative configurations, differences in the value of the geographic adjuster for an area are generally moderate. Statewide payment area configurations tend to have smaller differences across boundaries but track differences in practice input prices less well than the other configurations.

Before developing a recommendation on payment areas, the Commission plans to evaluate several combinations and variations of the three principal configurations. For example, the definition of statewide payment areas could exclude those MSA's with populations above some threshold, each of which would have its own adjuster. Alternatively, the current payment areas could be retained except that some of the smaller ones would be consolidated by HCFA. Another option would reconfigure the nonmetropolitan portions of states into two segments, according to population density and proximity to large MSAs. Finally, an urban core could be designated as a payment area separate from the remainder of a large MSA.

ACCURACY OF THE GEOGRAPHIC ADJUSTER IN RURAL AREAS

The geographic practice cost index (GPCI), which is the basis for the geographic adjuster in the Medicare Fee Schedule may not accurately reflect practice costs in rural areas, especially those that are far from major metropolitan areas. The GPCI is an index of

relative prices of practice inputs in a payment area. Proxies used for certain components of the GPCI, such as those for salaries of nonphysician employees and office rent, may understate costs in rural areas. The national cost weights used in the index may not reflect cost proportions in rural practice, which could affect the level of the GPCI in rural areas. Finally, the diseconomies of small practices in rural areas are not reflected in the GPCI.

In a hearing specifically devoted to rural practice costs, the Commission listened to testimony on these issues from rural practice consultants, practicing rural physicians, and managers of a large rural group practice with small satellite practices. Much of the information presented suggested that practice costs in rural areas are comparable to those in urban areas and, in some instances, higher. On the basis of this hearing, a number of studies were initiated. These include analysis of alternative proxies for GPCI components, analysis of cost weights for alternative definitions of rural areas, and simulations of GPICs using alternative cost weights. In addition, the Commission staff is using data from its own physician survey to study the scale economy issue. These analyses, to be completed during the next few months, will provide background for Commission consideration of recommendations for modifying the GPCI or the manner in which it is applied to payment in rural areas.

INTEGRATING ANESTHESIA, RADIOLOGY, AND PATHOLOGY SERVICES INTO THE FEE SCHEDULE

Although OBRA89 stated that relative values should be based on the time and intensity of physician effort as well as practice expense, and PLI costs, it did not specify how these values were to be measured. It did, however, specify a role for existing fee schedules for anesthesia and radiology. While adjustments will be required to make payment for these services consistent with that for other physicians' services, the legislation specifies the use of existing relative values in each of these fee schedules.

The Commission has studied the Uniform Relative Value Guide (URVG) used by Medicare for anesthesia services. Relative values are based on the time and the complexity of the anesthesia procedure.⁵ The Commission has concluded that the URVG is resource based and would be suitable for setting the relative payments among anesthesia services. The Commission's remaining task is to propose adjustments to the conversion factors in the URVG so that payments for anesthesia services are in correct relation to payments for other physicians' services. The Commission will also study the implications of the Medicare Fee Schedule and Volume Performance Standards for payment to Certified Registered Nurse Anesthetists.

⁵ The URVG is based on the 1988 edition of the American Society of Anesthesiologists' *Relative Value Guide* (RVG). The RVG also includes modifiers for the condition of the patient, but these are not used to set Medicare payment.

The Commission has less confidence in the current version of the Radiology Fee Schedule that Medicare has used to pay for the services of radiologists (but not for other physicians performing radiology services) since April 1989. It was developed by the American College of Radiology on the basis of survey data on charges and a magnitude estimation survey that estimated relative complexity. Panels of radiologists modified the relative values on the basis of their personal judgments.

While the Radiology Fee Schedule does have some significant departures from relative values based on charges, the process through which it was developed has both methodological and organizational shortcomings. For example, the charge survey had a low response rate, and the sample for the magnitude estimation study was clearly not representative. Physicians in specialties other than radiology, who account for one-third of radiology services in Medicare, had no role in developing the schedule, and there is some question about the involvement of nuclear medicine specialists.

The Commission has concluded that the Radiology Fee Schedule requires revision before it is incorporated into the overall Medicare Fee Schedule. It plans to develop proposals for revision through its refinement process, which will entail convening an appropriately representative panel of physicians who provide radiology services. The panel will be given relevant information, including the results from the Hsiao study for radiology and nuclear medicine, to consider modifications to the current fee schedule for radiology. More accurate specification of practice costs and technical components for radiology services will draw on the Commission's practice cost studies and, if available, surveys by the American College of Radiology. Once this revision is complete, the Commission will advise the Congress on methods to adjust the radiology relative values so that payments for radiology services are in proper relation to payments for other physicians' services.

Pathology differs from the other two specialties in that there is no existing fee schedule on which to draw. OBRA87 directed the Department of Health and Human Services (HHS) to propose a fee schedule for pathology; a provision of OBRA89 directed HHS to implement a fee schedule by January 1991. But the Commission is skeptical about the prospects of developing a resource-based scale for pathology without drawing on the Hsiao restudy of the specialty. That effort is unlikely to be completed until late 1990.

Implementing such a fee schedule risks delaying achievement of the goal of a resource-based scale. It will cause disruption for pathologists, many of whose 1991 payments would change in a manner that does not bring them closer to resource-based payments. The Commission urges the Congress to reconsider its specification of a separate fee schedule for pathology so that payments for these services can be determined under the Medicare Fee Schedule in the same manner as for most other specialties.

PAYMENT TO LIMITED LICENSE PRACTITIONERS

The Medicare Fee Schedule will apply not only to doctors of medicine (MDs) and osteopathy (DOs) but to physicians referred to as limited license practitioners (LLPs), specifically:

- o doctors of dental (oral) surgery or dental medicine;
- o doctors of podiatric medicine;
- o doctors of optometry; and
- o doctors of chiropractic medicine meeting certain educational and licensing standards.

LLPs are heterogenous in terms of training, practice characteristics, and the extent to which their services overlap with those provided by MDs and DOs. The Commission thus chose to make separate recommendations for each type of LLP concerning how to establish payment rates for their services under the fee schedule. Underlying all of these recommendations, however, is the principle that payment should be the same when the service is the same.

Because oral and maxillofacial surgeons were surveyed in the first phase of the Hsiao study, the Commission already has resource-based relative values for their services. In addition, cross-specialty links have been established that permit comparison of intraservice work between oral and maxillofacial surgeons and MD specialties. Therefore, the Commission recommends that oral and maxillofacial surgeons should be paid under the Medicare Fee Schedule, using the same relative values and conversion factors that are applied to MDs and DOs.

To use data on resource costs for MD and DO services to assign relative values for services provided by podiatrists and optometrists requires clarification of several issues. It is not known whether there are significant differences between these LLPs and MDs and DOs in the services provided and billed under the same Current Procedural Terminology (CPT) code developed by the AMA.

Before making recommendations on how to pay these categories of LLPs under the Medicare Fee Schedule, the Commission will convene focus groups to assess whether services billed under the same CPT code are in fact the same. If the services are the same, then payment should be the same. If the services are different, then the Commission will develop recommendations for changes in coding and will suggest how payment for the new code should compare to that for the existing code. Additional data collection may still be necessary to refine relative values for procedures in which LLPs

dominate (such as correction of bunion), so that estimates of time and work for their services are valid.

Finally, because of difficulties in linking chiropractic services into the Medicare Fee Schedule, a separate budget neutral fee schedule that incorporates a geographic adjuster should be constructed for the single service (spinal manipulation) that is covered by Medicare.

FINANCIAL PROTECTION FOR BENEFICIARIES

OBRA89 will provide substantial financial protection to most Medicare beneficiaries, reducing balance billing in the aggregate and eliminating balance bills that are very large. The Commission remains concerned about potential adverse effects of balance billing, especially in situations where the beneficiary has no meaningful choice of physician. It plans to monitor closely assignment and participation rates in the Medicare program. It will also continue to analyze the burden of balance billing on beneficiary populations and will recommend further policy changes if appropriate.

The Commission has planned further studies of beneficiary financial liability, relationships with physicians, understanding of assignment and participation, and access to care. It will link Medicare claims data to the survey data collected in late 1988. With this file, it will study costs for assigned and unassigned care among different demographic groups, beneficiary discussion of bills with physicians, and beneficiary willingness to seek out physicians who provide care on an assigned basis. Using a 5 percent sample of beneficiary claims, the Commission will identify tracer services for monitoring access to care and examine the potential of using balance bills as an indicator of access. Commission staff have been participating actively in advising HCFA on the design of the Current Beneficiary Survey, which will be a key data source for monitoring access.

The Commission examined protection of beneficiaries from charge limit violations and from charges denied by carriers because they reflect unacceptable billing practices. The regulations implementing charge limits under the Medicare Fee Schedule must make it clear to carriers, physicians, and beneficiaries that the limits apply to the total Medicare-allowed charge after the carrier has applied any reductions or denials related to unacceptable billing practices. Carriers should monitor compliance with charge limits on each claim as part of their routine claims processing activity and should notify physicians of any suspected violations and their potential consequences.

SETTING MEDICARE VOLUME PERFORMANCE STANDARDS

OBRA89 specifies an annual process in which both HHS and the Commission will make recommendations to Congress on setting the performance standard for the following year. The Commission must comment on the HHS proposal and submit its own recommendations by May 15 each year. In preparation for this task, it has focused on measuring the factors that will be relevant to setting the performance standard. The Commission will draw on all available sources of information in reaching its decisions.

Setting the performance standard is a decision that affects the amount of federal resources devoted to the Medicare program. Since federal resources are limited, the Congress wants Medicare to pay only for those services that constitute appropriate care. The ability to do this is limited in the short run, however, because it is difficult to use payment incentives to slow the growth in volume sharply without reducing access to care. As methods to identify and correct inappropriate utilization are improved, decisions to set the performance standard can more closely reflect objective assessments of appropriate levels of service.

OBRA89 directs HHS and the Commission to assess a range of factors when making recommendations regarding annual performance standards. These include inflation, growth and aging of the Medicare population, changes in technology, evidence of inappropriate utilization, and indications that Medicare beneficiaries lack access to necessary services.

Inflation has been measured by the Medicare Economic Index (MEI), but revision of the indicator is long overdue. The Commission applauds HCFA's recent initiative to improve the MEI and will tailor its own work plans on the MEI according to what is accomplished.

Although accounting for demographic change is relatively straightforward, measuring the effects of changes in technology is difficult. The Commission plans to identify those technologies that are most likely to affect expenditures and to convene an expert panel, comprised of physicians, beneficiaries, and health services researchers to evaluate and augment this information. The panel will consider which technological changes are likely to benefit patients enough to be accommodated in the performance standards.

It is generally agreed that many services are provided inappropriately. AHCPR support for research on effectiveness and the development of practice guidelines will contribute to assessment of the degree of inappropriate utilization. But inappropriate utilization and lack of access to necessary services are defined in a static sense rather than as changes over time. This will make it more difficult to devise a method to adjust the performance standard on the basis of an estimate of the proportion of inappropriate services. To monitor access, the Commission plans to use existing data and the forthcoming Current

Beneficiary Survey to quantify specific access problems and to follow indicators of overall access by the Medicare population.

Currently, the performance standard will encompass physician services and other services, such as clinical laboratory diagnostic tests that are commonly performed by physicians or in physicians' offices.⁶ To provide more options for physicians to respond to the VPS incentives, the scope of included services could be expanded to include other Medicare Part B services that are ordered by physicians or inpatient services. A decision to broaden the application of VPS should await further improvements in the Medicare data system and some experience with the current scope of included services, however.

SUBNATIONAL VOLUME PERFORMANCE STANDARDS

As an alternative to a national VPS, subnational standards could focus incentives for controlling the volume of services on groups of physicians that are smaller, more cohesive, and better organized. Such groups are better positioned to influence their members' practice patterns. Since physician education and practice guidelines are largely the province of specialty societies, standards might be constructed by specialty or by type of service. Since organizations that conduct peer review tend to be constituted by state, standards might be established for each state. Whether determined by state or by specialty, the subnational standard would be set in light of the need to match responsibility for expenditures with the control the entity exercises over them. But difficult conceptual and technical problems must be confronted with either type of subnational standard.

Current legislation calls for establishing separate performance standards for surgery and for all other services, but this may prove difficult. First, setting a performance standard for surgery requires an informed judgement about differences in the appropriate growth rate of spending for this versus other medical services, which is beyond current capabilities. Second, differential fee updates may drive relative values for procedures away from a resource basis, potentially sacrificing a key goal of the payment reform. Third, having separate performance standards for surgery and for all other services would leave a category of services without a cohesive set of specialties potentially capable of responding in a coordinated manner.

Given these difficulties, evidence that surgeons' organizations have taken substantial steps to improve and expand educational and peer review efforts should be a prerequisite for continuing a separate performance standard for surgery. Separate standards for narrower categories of services, such as the services performed by a single subspecialty, should not be considered until the problems with standards for surgery are resolved.

⁶ Certain services that meet this definition, such as diagnostic tests in hospital outpatient departments, have been excluded from the VPS policy because Medicare carriers do not process these claims.

State-level standards confront a different set of problems. Current state-level expenditure data for Part B are neither accurate nor timely enough to use in calculating payment updates. These data show highly variable rates of growth from year to year. The consistency and accuracy of data reporting should be reassessed once HCFA's new Common Working File claims reporting system is fully operational, before the end of 1990.

Setting objective differential standards by state rather than by specialty is closer at hand. Differential standards could be used to reduce the magnitude of variation in per-enrollee expenditures across regions of the country. But the question of how much and how quickly these differences should be reduced is a difficult one, both technically and politically. Since state-level standards are not technically feasible at this time, there is little reason to make a quick decision. While the overall issue is studied, however, state-level performance standards could be implemented on a waiver basis in response to requests from states experimenting with broad policies to contain costs, such as all-payer systems of physician payment.

PHYSICIANS' ALTERNATIVES TO VOLUME PERFORMANCE STANDARDS

An alternative mechanism to focus cost containment incentives on narrower groups of physicians would be to develop separate performance standards for voluntarily formed groups of physicians. OBRA89 directs HHS to develop a plan for such carve outs, but requires Congressional approval before it can be implemented.

Since 1985 Medicare has provided an option for groups of physicians to have Medicare payments based in part on their success in limiting utilization. Under Medicare risk contracting with health maintenance organizations (HMOs), such health plans are paid 95 percent of the amount that Medicare estimates it pays for fee-for-service care in the local community. These HMOs are already excluded from the VPS policy.⁷

The Commission believes that energies would be better spent on improving the existing HMO risk-contracting option than on devising carve-out group options. In previous reports, it has made recommendations to Congress on aspects of Medicare risk contracts. In the near future, the Commission will consider a number of policy changes to make this option more attractive to beneficiaries, HMOs, and the Medicare program. These include refining the payment mechanism to reflect the medical needs of those enrolling in each plan more accurately, increasing financial incentives to beneficiaries to enroll, and modifying requirements that health plans must meet in order to qualify.

⁷ HMOs are indirectly affected by the VPS policy, however, since their payment continues to be based on Medicare's experience in fee for service.

The Commission considered a number of ways in which a VPS carve-out system could be designed but none appears workable. One serious problem concerns how to determine whether a group has kept expenditure growth within its performance standard. This requires attributing service use by each beneficiary to a specific group. If attribution were through enrollment, the group would have to offer beneficiaries an economic incentive to enroll and would incur marketing expenses. The potential rewards to the group of physicians would probably not be large enough to offset these costs. Alternatively, beneficiaries could be assigned to a physician group statistically on the basis of which physicians they use. This, too, would create a number of complex issues, including where to assign beneficiaries who do not use services at all and how to assign those who use both physicians in the group and outside the group.

Once beneficiaries were assigned to carve-out groups, difficulties would also be encountered in comparing performance standards with expenditure increases for each group. The relatively few beneficiaries in many of these groups would cause variations in expenditures related to incidence of illness to overshadow the group's efforts to manage care.

THE FEDERAL GOVERNMENT'S ROLE UNDER VOLUME PERFORMANCE STANDARDS

The success of the VPS system will depend upon the extent to which physicians work cooperatively with the research community and the Medicare program to identify and control unnecessary and inappropriate services. The payment reform legislation helps physicians meet this challenge by giving HHS and its contractors new responsibilities for analyzing utilization trends and by providing information to physicians on possible utilization problems. It also requires carriers to monitor and profile physicians' billing patterns and provide comparative data to physicians whose utilization patterns vary significantly from those of their peers. To advise the Congress on how to realize the full potential of these tools, the Commission plans to study mechanisms of profiling physicians and methods of using the information developed.

Unfortunately, carrier budgets for medical review activities have been unstable and increasingly inadequate. Solving this problem will likely require changes in the method by which carrier funding is treated in the Congressional budget process. The problem is that carrier funding needs are largely determined by Medicare beneficiaries' use of services and increased review responsibilities mandated by the Congress. Yet carrier budgets come from a discretionary (nonentitlement) account. This means that funding for administration of Medicare must compete with numerous nondefense programs, such as education and biomedical research, for extremely limited resources. The process should be revised so that baseline budget levels for carrier activities reflect projected increases

in claims. Funding for additional review activities that will reduce spending for benefits should not be subtracted from what is available for other nondefense discretionary programs.

AHCPR will also play a crucial role in developing the knowledge base required to support a VPS system. In addition to its other broad responsibilities for the study of medical effectiveness and development of practice guidelines, the agency has been charged with promoting and supporting the development and dissemination of review criteria and performance measures to be applied by review organizations. AHCPR and other HHS agencies should give priority to developing systems for both profiling physician practices and disseminating information on patterns of utilization to researchers, professional organizations, and individual physicians.

LEGAL IMPEDIMENTS TO PHYSICIAN EFFORTS TO INCREASE APPROPRIATENESS OF CARE

Physicians have raised concerns about legal impediments to the development and use of practice guidelines and physician participation in utilization review. The Commission consulted with a wide range of attorneys expert in antitrust law and medical malpractice. It also drew on the recently completed AMA study of the legal implications of practice parameters (American Medical Association, 1990). The Commission concluded that the risk of antitrust suit for a medical professional organization that develops and disseminates guidelines is slight as long as the organization follows reasonable procedures in doing so. It decided not to recommend legislation to provide additional protection for these activities.

Concerning malpractice, increased availability of practice guidelines and review criteria is not likely to pose practitioners with additional risks of a suit. Guidelines are likely to make determinations of negligence more accurate and reduce the incidence of unfounded suit, so that the system will function somewhat more efficiently. However, the major problems with the malpractice system will not be addressed through practice guidelines.

Currently available research suggests that the tort system neither reliably compensates those injured through medical negligence nor reliably disciplines negligent physicians. The system is expensive, in that a large portion of physicians' PLI costs do not go to injured patients. Defensive medicine is a factor in high medical costs and sometimes interferes with physician-patient relationships. A number of studies that are under way will provide the Commission with needed information to develop alternatives for reforming the malpractice system. In the coming year, the Commission will consider the evidence and review alternatives for reform.

PHYSICIAN PAYMENT IN MEDICAID PROGRAMS

There is growing concern about physician payment rates under the Medicaid program. Low fee levels may discourage physicians from treating Medicaid patients, thereby limiting beneficiary access to mainstream medical care. OBRA89 directs the Commission to examine the adequacy of physician payment, physician participation, and access to care by Medicaid beneficiaries. The study and accompanying recommendations are due by July 1, 1991.

To begin its work, the Commission has conducted background research on state Medicaid program characteristics, focusing on physician payment methods. It has also reviewed previous research studies that analyzed how Medicaid fee levels affect beneficiary access to care and program expenditures.

The Commission has developed a research plan for the coming year. These activities include:

- o collecting additional descriptive information on Medicaid physician payment through a contract with the National Governors' Association to survey state Medicaid programs;
- o conducting analyses on how fee levels appear to affect both the use of Medicaid services and Medicaid program expenditures;
- o analyzing the experiences of states that have changed physician fee levels to determine how these changes appear to have affected access and expenditures; and
- o modelling the effects of alternative policy changes.

These activities will provide the Commission with much of the information necessary to develop recommendations to Congress on the reform of Medicaid physician payment policies.

The Commission recognizes that it will also be important to draw upon the experience of state Medicaid officials. The states have already experimented with various approaches to improve access to physician care under Medicaid. Some states have decided to increase physician payment to improve beneficiary access. Others have found different approaches, such as expanding managed care options and reducing administrative burdens, to be more effective.

REFERENCES

American Medical Association, *Legal Implications of Practice Parameters*, in press, Chicago: American Medical Association.

Hsiao, W.C., P. Braun, E. Becker, et al., *A National Study of Resource-Based Relative Values Scales for Physician Services: Final Report*, Harvard School of Public Health, September 1988.

Physician Payment Review Commission (PPRC), *Annual Report to Congress 1989*, Washington, D.C., 1989a.

Physician Payment Review Commission (PPRC), *The Costs of Providing Screening Mammography*, Report to Congress No. 89-2, Washington, D.C., 1989b.

CMS LIBRARY



3 8095 00012827 8